DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Management and Technology
DMT-983 (11/05)

STATE OF WISCONSIN
AD 19.1, 31.8, 60.3, 52.3, 36.4;32.6

CIVIL RIGHTS COMPLAINT

Any consumer of Department of Health and Family Services (DHFS) services and benefits funded by the U.S. Department of Health and Human Services (DHHS) may file a civil rights complaint at any time with the DHFS Affirmative Action and Civil Rights Compliance (AA/CRC) Office.
You may also file a discrimination complaint with the U.S. DHHS Office for Civil Rights, Region V. Any complaint about Food Stamps, WIC or The Emergency Food Assistance Program (TEFAP) must be filed with the USDA.
Complaints filed with the U.S. DHHS and USDA must be filed within 180 days of the alleged discriminatory act.

SECTION I – COMPLAINANT

Important! The complainant must notify the DHS AA/CRC Office if there is a change in address or telephone number. If the office is not able to locate the complainant, the complaint may be closed.

First Name	Middle Initial	Last Name	Filing Date

Address – Street	City	ZIP Code	County

Home Telephone Number	Work Telephone Number	E-mail Address	FAX

SECTION II – RESPONDENT / PROVIDER INFORMATION

Name – Organization / Agency	Type Org. County, City, State	☐ For Profit ☐ Non-Profit

Name – Person Representing Respondent	Organizational Title

Address – Representative	City	ZIP Code	County

Telephone Number – Include Area Code and Extension	E-mail Address

SECTION III – REASON FOR DISCRIMINATION

Check only the boxes that are the reason for your complaint. If you checked a box with an asterisk (*), you must provide your protected status or preferred language here:

☐* Color	☐ Religion	☐* Age (40 or over) – Birthdate:
☐* Disability	☐ Political Affiliation	☐ National Origin or Limited English Proficiency – Preferred
☐* Gender ☐* Race / Ethnicity	☐ Retaliation	Language:
☐ Other:		

SECTION IV – DISCRIMINATION STATEMENT

Use additional pages, as is necessary, to fully complete this section.

1. Describe the events that led you to file this complaint.
2. Give the date each action occurred and name of the person who took the action.
3. Explain how each action was related to the box(es) you checked in Section III.

SECTION V – CERTIFICATION AND SIGNATURE

By my signature below, I declare this complaint is true and correct to the best of my knowledge and belief.

_____ _____
SIGNATURE - Complainant Date Signed

Mail To: DHFS Affirmative Action & Civil Rights Compliance Office
1 W. Wilson, Box 7850
Madison WI 53707

Other Contact Information
FAX : 608-267-2147
E-Mail: cowelre@dhfs.state.wi.us.

DMT-983 (11/05) SECTION IV – DISCRIMINATION STATEMENT CONTINUATION